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Office of Communicable Diseases
Legionella

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Legionella Investigation – RI Definitions & Rules for Entering Investigation

Note: **RED = Required**, **BLUE = Required Conditionally,** BLACK = Not Required

Brief Description or Field Name	Description	RI Rules for Data Entry
Investigation Summary		
Jurisdiction	**The region responsible for the investigation. RI has only 1 jurisdiction**	**Required**
Program Area	**The organizational ownership of the investigation. Program areas (e.g. General Communicable Diseases, Hepatitis, STD, HIV/AIDS, Vaccine Preventable) are defined by the conditions for which they provide primary prevention and control. This is pre-populated based on the condition.**	**Required**
State Case ID	Open field to be used by OCD, if needed.	Not Required
Investigation Start Date	**Date the investigation was entered into NEDSS.**	**Required**
Investigation Status	**The status of the investigation: Open or Closed. Leave as OPEN until the investigation is completed (i.e. until all pertinent facts necessary to evaluate the risk and determine if treatment is necessary.) Then change to CLOSED**	**Required**
Share record with Guests	This field indicates whether or not the record should be shared with all users who have guest privileges for the Program Area/Jurisdiction. Defaults to checked. OK to leave checked. Not in use by RI at this time	Not Required
Investigator	**The name of the person who is responsible for the case investigation. Quick code = first initial of first name +first 5 letters of last name.**	**Required.**
Date assigned to Investigation	The date that the Investigation was assigned to the investigator or the date the investigator started the investigation if self-assigned	Not Required
Reporting Source		
Date of Report	Date first reported by reporting source if reported by phone or date received by person on-call if animal bite.	Not Required
Reporting Source	**Type of facility or provider associated with the source of information sent to Public Health. For Animal Rabies it would be the Health Laboratory**	**Required**
Earliest Date Reported to County	Date first reported to County	Not Required
Earliest Date Reported to State	**Date first reported to State**	**Required**
Reporter	Search table for who Reported the case	Not required.

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Brief Description or Field Name	Description	RI Rules for Data Entry
Clinical		
Physician	**Search table for patient's physician.**	**Required if known**
Was the patient hospitalized for this illness?	**Was the patient hospitalized for this illness?**	**Required, if known**
Diagnosis Date	Date of diagnosis of condition being reported.	Not required
Illness Onset Date	**Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system. Enter date of 1st symptom related to this illness**	**Required, if known**
Illness End Date	**The time at which the disease or condition ends.**	**Required, if known**
Illness Duration	**The length of time this person had this disease or condition. Must calculate from End Date and Onset Date**	**Required, if known**
Age at Onset	**Subject's age at the time of the incident**	**Required if NO DOB, otherwise not required**
Is the patient pregnant?	**Assesses whether or not the patient is pregnant. For Female patients only.**	**Required for Hepatitis only**
Does the patient have pelvic inflammatory disease?	Did the patient have PID?	Not Required
Did the patient die from this illness?	**Did the patient die from this illness?**	**Required, if known**
Epidemiologic		
Is this patient associated with a day care facility?	Indicates whether the subject of the investigation was associated with a day care facility. The association could mean that the subject attended daycare or work in a daycare facility.	Not Required
Is this patient a food handler?	Indicates whether the subject of the investigation was food handler.	Not Required
Is this case part of an outbreak?	**Denotes whether the reported case was associated with an identified outbreak.**	**Required – fill in "No" unless given specific directions otherwise.**
Where was the disease acquired?	**Indication of where the disease/condition was likely acquired.**	**Required**
Transmission Mode	Code for the mechanism by which disease or condition was acquired by the subject of the investigation.	Not required
Detection Method	Code for the method by which the public health department was made aware of the case.	Not required
Confirmation Method	Code for the mechanism by which the case was classified. This attribute is intended to provide information about how the case classification status was derived. Example: Clinical diagnosis (non-laboratory confirmed), Epidemiologically linked, Laboratory confirmed, Unknown	Not required
Confirmation Date	The date the case was confirmed.	Not required

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Brief Description or Field Name	Description	RI Rules for Data Entry
Case Status	Indication of the level of certainty regarding whether a person has a disease/condition. Where applicable, is defined by CSTE/CDC Standard Case Definition. For example: Confirmed, Probable or Suspect case.	Required
MMWR Week	MMWR Week for which case information is to be counted for MMWR publication. Pre-entered field.	Not Required
MMWR Year	MMWR Year (YYYY) for which case information is to be counted for MMWR publication. MMWR year must correspond to year that the event occurred. For example: if the event occurred in Dec 2007 and you entered the information into NEDSS in Jan 2008 you will need to change the MMWR year to 2007	Required
Administrative		
General Comments	Field which contains general comments for the investigation.	Not Required
Condition Specific Custom fields		
Travel or stay overnight somewhere other than their usual residence?	Yes/No/Unknown	Required
If Yes, give cities and lodging detail:	Cities and lodging detail	Required (if applicable)
Have Dental Work?	Yes/No/Unknown	Required
If Yes, name of dental office:	Name of dental office	Required (if applicable)
Visit a hospital as an outpatient?	Yes/No/Unknown	Required
If Yes, name of hospital:	Name of hospital	Required (if applicable)
Work in a hospital?	Yes/No/Unknown	Required
If Yes, name of hospital?	Name of hospital	Required (if applicable)
Was Case hospital related (nosocomial)?	Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms. / Definitely nosocomial: Patient hospitalized continuously for ≥ 10 days before onset of legionella infection. / Possibly nosocomial: Patient hospitalized 2 - 9 days before onset of legionella infection. / Other (Specify) / Unknown	Required
If Other, specify:	Enter other hospital-related case status. Free text	Required (if applicable)
Diagnosis:	Legionnaires' Disease (Pneumonia, X-ray diagnosed) / Pontiac Fever (fever, myalgia without pneumonia) / unknown / other (specify)	Required
Smoking Status	Everyday smoker / Former smoker / Non-smoker / Occasional smoker / Unknown	Required

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Brief Description or Field Name	Description	RI Rules for Data Entry
Chronic conditions	Yes/No/Unknown	Required
If yes, specify chronic conditions	Enter chronic conditions, if any, of case. Free text field.	Required
Immunosuppresion	Does case suffer from immunosuppression? Yes / No / Unknown	Required
COPD	Does case suffer from Chronic Obstructive Pulmonary Disease (COPD)? Yes / No / Unknown	Required
Asthma	Does case suffer from asthma? Yes / No / Unknown	Required
Occupation	Enter occupation of case. Free text field.	Required
Workplace (Name and Address)	Enter workplace (name and address) of case. Free text field.	Required

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NEDSS - Windows Internet Explorer

https://www.site3.asp.csc.com/nbs/ViewInvestigation3.do?ContextAction=Edit

Live Search

File   Edit   View   Favorites   Tools   Help

Page ▾   Tools ▾

Home | Data Entry | Merge Patients | Investigations | Reports | System Admin | Help | Logout

Edit Investigation   User: Leanne Chiaverini   STAGING

Patient ID: 32000 | Investigation ID: CAS10021001RI01

○   ○
Submit Cancel

Created: 03/05/2007 by: Leanne Chiaverini Updated: 05/10/2007 by: Helen McCarthy

Name: quahog digger DOB: 01/01/2001 Current Sex: Male

Patient | Ehrlichiosis, Human monocytic

Investigation Summary | Reporting Source | Clinical | Epidemiologic | Administrative | Condition Specific Custom Fields

Investigation Summary   Back to Top

* Jurisdiction: RI
Program Area: General Communicable Disease
State Case ID: [   ]
Investigation Start Date: [05/08/2008]   **Date that investigation is STARTED IN NEDSS.**
                          mm/dd/yyyy
Investigation Status: [Open ▾]

☑ Share record with Guests for this Program Area and Jurisdiction

Investigator

[Search] [Clear]   [lchiav] [Code Lookup]

Investigator: LEANNE CHIAVERINI
              DEPARTMENT OF HEALTH
              3 CAPITOL HILL
              PROVIDENCE, Rhode Island 02908
              401-222-4756

Date Assigned to Investigation: [   ]
                                mm/dd/yyyy

Reporting Source   Back to Top

Date of Report: [   ]
                mm/dd/yyyy

Reporting Source: [Laboratory   ▾]

[Search] [Clear]   [   ] [Code Lookup]

Reporting Source: SOUTH COUNTY HOSPITAL
                  401-789-9765
                  401-782-8020
                  100 KENYON AVENUE
                  WAKEFIELD, Rhode Island 02879

Earliest Date Reported to

County: [   ]   State: [05/01/2008]
        mm/dd/yyyy   mm/dd/yyyy

Reporter

[Search] [Clear]   [   ] [Code Lookup]

Reporter: There is no Reporter selected.

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Clinical   Back to Top

Physician

[Search] [Clear]   [   ] [Code Lookup]

Physician: DEIRDRE SMITH
            INTERNAL MEDICINE ASSOC INC
            SUITE 201
            CRANSTON, Rhode Island 02920-0000
            401-943-1300

Hospital

Was the patient hospitalized for this illness?   [No   ▼]

Condition

Diagnosis Date: [   ] 📅
                    mm/dd/yyyy

Illness Onset Date: [04/28/2008] 📅   Illness End Date: [   ] 📅
                    mm/dd/yyyy   mm/dd/yyyy

Illness Duration: [   ] [Days ▼]

Age at Onset: [   ] [Years ▼]   **Required if NO DOB, otherwise not required.**

Is the patient pregnant?   [▼]

Does the patient have pelvic inflammatory disease? [▼]

Did the patient die from this illness? [No] [▼]

Epidemiologic   Back to Top

Is this patient associated with a day care facility?   [▼]

Is this patient a food handler?   [▼]

Is this case part of an outbreak?   [▼]   **Required – fill in "No" unless given specific directions otherwise.**

Where was the disease acquired?   [▼]

Transmission Mode: [▼]

Detection Method: [▼]

Confirmation Method: *(Use Ctrl to select more than one)*
                    [Laboratory confirmed   ▲]
                    [Laboratory report   ]
                    [Local/State specified   ■]
                    [Medical record review   ]
                    [No information given   ▼]

Confirmation Date: [   ] 📅
                    mm/dd/yyyy

                    (Required for Notification)
Case Status: [Probable ▼]

                    (Required for Notification)
MMWR Week: [10]

                    (Required for Notification)
MMWR Year: [2008]

Administrative   Back to Top

General Comments: [   ]
                    [   ]
                    [   ]

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Condition Specific Custom Fields   Back to Top

In the two weeks before onset, did the patient

Travel or stay overnight somewhere other than their usual residence?   [No ▼]

If Yes, give cities and lodging detail:
```
Coventry RI, Feb3 - Feb8th 2007,
Tuscany, Italy, Greece, here, there,
everywhere, from Dec 20 -
```

Have Dental Work?   [No ▼]

If Yes, name of dental office: [   ]

Visit a hospital as an outpatient?   [No ▼]

If Yes, name of hospital: [   ]

Work in a hospital?   [No ▼]

If Yes, name of hospital?   [   ]

Was Case hospital related (nosocomial)?   [Not nosocomial ▼]

If Other, specify: [   ]

Click for definition of "Definitely nosocomial"

Click for definition of "Possibly nosocomial"

Click for definition of "Not nosocomial"

Diagnosis: [Legionnaire's Disease (Pneumonia ▼]

Smoking Status: [▼]

(Use Ctrl to select more than one)

Chronic conditions?
```
No
Unknown
Yes
```

If yes, specify chronic conditions: [   ]

(Use Ctrl to select more than one)

Immunosuppression?
```
No
Unknown
Yes
```

(Use Ctrl to select more than one)

COPD?
```
No
Unknown
Yes
```

(Use Ctrl to select more than one)

Asthma?
```
No
Unknown
Yes
```

Occupation: [   ]

Workplace (Name and address):   [   ]

Patient   Legionellosis

Submit   Cancel